Health Care Experiences of Black Transgender Women and Men Who Have Sex With Men: A Qualitative Study

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Abstract

Black sexual and gender minorities (SGM) are at greater risk for HIV compared to their White, cisgender, heterosexual counterparts. Linkage to culturally sensitive health care is, therefore, pivotal for HIV prevention and treatment of Black SGM. Unfortunately, social and structural challenges undermine Black SGM individuals' abilities to obtain adequate health care services, indicating a need to understand Black SGM perceptions of health care. To address this gap, we interviewed Black men who have sex with men and transwomen about their experiences with health care providers. Participants discussed needs and concerns, including provider SGM identity diversity and education; assumptions, judgment, stigma, and discrimination; and ability to establish a personal bond, trust, and familiarity. Black SGM indicated that providers often did not meet their needs in different ways regarding their SGM identities. Findings suggest a need for provider cultural sensitivity education programs that address the needs of Black SGM in health care.

Key words: health care disparities, health care perceptions, sexual and gender minorities, LGBTQ+, qualitative

In the United States, men who have sex with men (MSM) make up more than 50% of persons living with HIV (PLWH), account for 67% of new HIV infections, and approximately 17% are unaware that they are living with HIV (Centers for Disease Control and Prevention, 2018). Transgender women (transwomen) are also at an increased risk for HIV; from 2009 to 2015, 2,351 transgender individuals were diagnosed with HIV in the United States, 84% of whom were transwomen (Clark, Babu, Wiewel, Opoku, & Crepaz, 2017). Racial disparities also exist in these populations; Black MSM and transwomen are at a disproportionately greater risk for HIV when compared to their White counterparts (Centers for Disease Control and Prevention, 2017, 2018; Clark et al., 2017), indicating that Black sexual and gender minority (SGM) groups are priority HIV-prevention populations.

According to the U.S. Department of Health and Human Services (2017), preexposure prophylaxis is a key element in reducing the risk of HIV acquisition in at-risk populations, whereas successful antiretroviral therapy prevents disease progression and HIV transmission for PLWH. The latter is the cornerstone of treatment as prevention, a core public health strategy to prevent HIV transmission by ensuring that PLWH are treated and maintain undetectable viral loads. Additionally, health care providers can be an important HIV-prevention resource and have been shown to reduce sexual risk behaviors (Raifman, Beyrer, & Arrington-Sanders, 2018). Therefore, entering and maintaining linkage to culturally sensitive health care is pivotal for HIV prevention and treatment of Black SGM.

Unfortunately, many social and structural challenges have undermined Black SGM individuals' abilities to receive competent care and desire to seek and be retained in health care services, including health care provider–related homophobia, stigma, discrimination, and health care system policies and environments that reduce access to culturally sensitive care, increase concerns about confidentiality, and increase fear of disclosing and discussing sexual orientation and gender identity (Arnold, Rebchook, & Kegeles, 2014; Fields, Morgan, & Sanders, 2016; James, Brown, & Wilson, 2017; Macapagal, Bhatia, & Greene, 2016). This indicates a clear need to

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examine health care experiences among Black SGM in order to address these challenges and inform efforts to improve HIV prevention services and treatment.

Qualitative studies have explored health care experiences among SGM (Dowshen, Lee, Franklin, Castillo, & Barg, 2017; Kosenko, Rintamaki, Raney, & Maness, 2013; Lykens, LeBlanc, & Bockting, 2018; Martos, Wilson, Gordon, Lightfoot, & Meyer, 2018) but rarely among predominantly Black SGM who are most at-risk for HIV. This is a significant limitation given the social and structural health care challenges and increased risk for HIV faced by Black SGM (Centers for Disease Control and Prevention, 2017, 2018; Clark et al., 2017; Fields et al., 2016; James et al., 2017). Indeed, researchers have emphasized that the current and existing body of literature has often examined health care perceptions among broader samples of SGM individuals and has called for more qualitative research to examine the health care experiences and preferences of specific SGM subgroups, such as Black SGM (Martos et al., 2018). In order to successfully address this issue, it is of utmost importance to understand what constitutes high- and low-quality experiences with health care providers from the perspectives of Black SGM. The aim of our study was to explore Black SGM perspectives about what characterizes experiences with health care providers as negative or positive, and recommendations for provider improvement. Therefore, we addressed the following research questions:

- What are *inappropriate* (patient indicated as uncomfortable or negative) provider interactions and experiences regarding HIV prevention and treatment?
- What are *appropriate* (patient indicated as comfortable or positive) provider interactions and experiences regarding HIV prevention and treatment?
- What are *recommendations for improvement* (patient indicated might create comfortable or positive experiences) in provider interactions and experiences regarding HIV prevention and treatment?

Method

Recruitment

Twelve individuals (six MSM men and six transwomen) participated in our study. A nonprobability convenience sampling strategy was used to select participants. To be eligible to participate, individuals had to self-identify as African American or Black; gay, bisexual, transgender, queer, or intersex; at least 18 years of age; and having been assigned male sex at birth (Table 1). MSM were recruited in or near the Washington, DC, metropolitan area via mobile geospatial dating apps (e.g., Grindr, JackD). Transwomen were recruited face to face through a transgender support group (five of six) held at a local community-based HIV prevention and treatment services organization in Largo, Maryland, and by referral (one of six) from someone who participated in the study. Recruitment took place between June 2017 and November 2017. Interested individuals were screened for eligibility prior to informed consent, and informed consent was obtained before all interviews. Our study was approved by the University of Maryland Institutional Review Board.

Data Collection Procedures

Each participant was interviewed in a private, quiet location of the participant's choice by one of the two trained, male, PhD student, research assistants who were sensitive to Black SGM health concerns; both identified as sexual and racial minorities with a primary area of research interest in SGM health. The research assistants were trained by the study principal investigator about cultural sensitivity and in-depth individual interview methods. The research assistants had no relationships with participants prior to the interviews, and participants only knew that interviewers were research assistants at the University of Maryland. Participants were first asked to provide demographic information and then asked open-ended questions using a semistructured interview guide to reveal experiences discussing sexuality/gender, sexual health, HIV-risk behaviors, HIV testing, and preexposure prophylaxis with health care providers. All questions were followed by prompts to encourage more detailed and complete responses. Interview lengths varied from 18 to 90 minutes (average = 40 minutes). Participants were compensated $30 for time spent participating in the study. All interviews were audio recorded and transcribed verbatim by a professional transcription service, after which transcripts were managed using Microsoft Word.

Data Analysis

Our inductive data analysis approach was guided by the six phases of thematic analysis (Braun & Clarke, 2006). The initial question that guided the creation of the semistructured interview guide and first and second phases of thematic analysis was *What are the health care provider–related needs of Black SGM individuals?* One of the lead members of the research team began by reading and rereading each transcript individually, making notes of interesting research topics and questions (Phase 1—becoming familiar with the data). He then conducted an inductive preliminary thematic

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Table 1. Sample Description

Pseudonym	Age, years	Race/Ethnicity	Sex Assigned at Birth	Gender Identity	Sexual Orientation	HIV Status
Elijah	32	African American	Male	Man	Gay	Negative
James	32	Black	Male	Man	Gay	Positive
Nicholas	31	Black/African American	Male	Man	Gay	Negative
Orlando	27	Black/African American	Male	Man	Gay	Positive
Robert	31	Black	Male	Androgynous	Gay/queer	Positive
Steven	29	African American	Male	Man	Gay	Positive
Alice	22	African American/ Latino	Male	Transgender woman	Queer	Negative
Beatriz	32	Black	Male	Transgender woman	Gay	Negative
Christine	30	African American	Male	Transgender woman	Straight	Negative
Helen	26	Black/African American	Male	Transgender woman	Bisexual	Negative
Jessica	27	Black	Male	Transgender woman	Bisexual	Negative
Marlene	31	Black/African American	Male	Transgender woman	Bisexual	Negative

analysis (Phase 2—generating initial codes), identifying passages and describing common themes related to the domains of the semistructured study interview guide. To do this, the research team member highlighted specific passages and attached a comment to each highlighted passage that included a thematic description and code for that passage. The research team (two behavioral health science faculty, one epidemiology faculty, and two public health doctoral students) met regularly during this process to review and discuss identified passages and codes and brainstorm potential research questions that could be explored using the data. During these meetings, team members read and discussed the passages and codes, and there were no disagreements at this stage. Based on the codes that were identified during this process, and through a collective team effort, the three overarching research questions emerged.

Next, one researcher served as the primary coder and began independently coding each transcript using the three preestablished research questions as a guide (Phase 3—searching for themes), categorizing text passages as inappropriate, appropriate, or recommendations for improvement in provider interactions/experiences according to each participant. The research team met on a weekly basis during the coding process to review the primary coder's progress and discuss any issues. This was followed by a secondary coder performing an interrater reliability check by assessing agreement/disagreement with all primary codes and coding any text within the transcripts that the primary coder had missed. Differences between primary and secondary coding were resolved at team meetings with both coders present. After primary and secondary coding were completed, the primary coder went through all coded passages and generated thematic key words or phrases that specifically described the main topics of the passages (Phase 4—interpreting the themes). The research team reviewed the key words/phrases and collectively identified the relatively common key words as main themes and the less common key words as subthemes (Phase 5—refining the specifics of the themes). There were no disagreements regarding the list of key words/phrases and main versus subthemes. The final list of themes and subthemes was inductively interpreted by the entire research team in regard to the three preestablished research questions (Phase 6—final analysis). The study's overarching themes emerged from this collective team process. Saturation was reached (i.e., no new information was emerging) in two of the overarching themes for both Black

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MSM and transwomen participants and in one additional theme specific to the transwomen subgroup.

Study Rigor

The study team used a number of strategies to enhance study rigor and trustworthiness of findings. Undue bias of any individual member of the research team was reduced through the use of multiple coders and triangulation of coding, regular peer debriefing throughout data collection and analysis, and maintaining an audit trail recording analytic decisions. The research team, especially the two coders, practiced reflexivity through regular discussion of their reactions to the study as it unfolded, particularly as findings began to emerge. Given that several members of the research team identify as sexual and/or gender minorities (both of color and not of color), we were able to reflect critically together on how emergent findings resonated with our own experiences of health care and those of other members of our communities. These measures helped to enhance study credibility (i.e., truth of the findings), confirmability (i.e., findings represent participant views without undue researcher bias), transferability (i.e., findings are applicable to others beyond those participating in the study), dependability (i.e., other researchers would come to similar findings given similar participants in similar conditions), and authenticity (i.e., extent to which the feelings and emotions of participants are represented in a faithful manner; Cope, 2014).

Results

All transwomen in the study were uninfected with HIV, Black, and 22–32 years of age. The majority of transwomen participants were living with family and/or roommates, employed, and receiving health care services at a culturally sensitive community-based organization (CBO). More than half of MSM were living with HIV (four of six), all were Black, and 27–39 years of age. Half of MSM participants resided with roommates and half lived alone, most were employed, and some were receiving health care services at CBOs and others at private medical practices. Sociodemographic information was obtained through self-report. See Table 1 for key participant characteristics.

Two overarching themes emerged from thematic analysis characterizing the experiences of Black MSM and transwomen with health care providers: *Sexual and Gender Minority Identity Diversity and Education* and *Assumptions, Judgment, and Discrimination*. One additional theme emerged specific to transwomen, *Establishing a Personal Bond, Trust, and Familiarity*.

Sexual and Gender Minority Identity Diversity and Education

Men who have sex with men and transwomen participants indicated the need for more SGM identity diversity among providers (i.e., more lesbian, gay, bisexual, transgender, and other SGM providers). Participants explained that having more providers with SGM identities would increase patient comfort when receiving health care services and discussing sensitive topics. For example, Helen, a 26-year-old bisexual transwoman, expressed her perception that some providers were uncomfortable delivering care for transgender patients, and her belief that more SGM providers could increase comfort for transwomen patients, "Because I know some of them be so uncomfortable. I think that if we had doctors and nurses that identify with us, then that would make us comfortable …. Diversity in the workplace" [Helen, 26, transwoman].

Participants cited experiences with SGM-identifying providers as often highly positive. For example, Alice, a 22-year-old queer transwoman, described a positive experience suggesting how SGM providers might be more relatable to SGM patients, providing further evidence for the need for more SGM providers:

> … He was not judgmental at all. He even told me that I didn't have nothing to worry about because he was actually gay himself, but he was a nonconforming [minority gender identity] gay person. That was when I first heard the term. [Alice, 22, transwoman]

Christine, a 30-year-old straight transwoman, similarly explained that her provider was "part of the community", and because her provider was SGM-identifying and a member of her own community, they were able to "have a very open relationship." Orlando, a 26-year-old MSM participant, detailed how SGM-identifying health care staff, specifically, can help patients perceive that staff are relatable, understanding, and nonjudgmental when delivering care to SGM patients, further emphasizing the need for more SGM providers:

> Just like police departments have gay liaisons and they have officers who actually register with the gay liaison to work with that same demographic, I think in the medical field, that should be the same thing to make people who feel like, okay, well if this person is gay, they can relate to me. Actually, I think that would help people come in to be treated more to feel like, "Oh, well I'm being seen by someone who is in the life and who can understand what I'm going through and not really be judgmental about it. [Orlando, 27, MSM]

Participants called for more SGM education for providers, regardless of provider SGM or non-SGM identities, offered by CBOs and stakeholders. They brought to light that this kind of education from the community

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could increase provider cultural sensitivity about providing care for SGM patients. Helen described this need in order to increase provider confidence and comfort delivering care to SGM patients and make SGM patients feel more comfortable:

> If they can raise awareness so you can have some type of class …. They can raise awareness and have a discussion about it. That can go a long way … if they brought it to the workplace, had a class about it. Probably one class, two class. They could get the feel of it. When they do interact with … someone from the community. They'll be able to do a bit more. I guess, confident. Make them feel comfortable so they can make the patient feel comfortable. [Helen, 26, transwoman]

James, a 32-year-old MSM participant, similarly emphasized the need for more education from SGM CBOs and stakeholders, noting that this was needed more now than in the past due to increasing numbers of SGM-identifying individuals:

> I feel like every physician, this day and age, should work with some type of community or outreach program, just to educate their physicians on the LGBT [lesbian, gay, bisexual, transgender] community because, I don't know, I feel like now, compared to maybe 20 years ago, a lot more people are coming out, more people are feeling more comfortable about being themselves. You have to get on the bandwagon. [James, 32, MSM]

Assumptions, Judgement, and Discrimination

Men who have sex with men and transwomen participants talked about different ways providers communicated that could either facilitate or hinder health care experiences and patient–provider relationships. They described provider communication involving verbal and nonverbal cues, such as body language, tone of voice, and demeanor that conveyed assumptions, judgment, and discrimination. Transwomen cited examples where providers questioned or rejected their gender identity, refused to deliver health care services to them, used negative and judgmental communication, and used incorrect pronouns. For example, Alice described her experience being refused health care services with a prior provider, highlighting the provider's discomfort with an SGM patient and inappropriate reactions and practices:

> I [transwoman] was at the hospital and she [physician] found out that I was gay, and she refused to stick the needle in me to give me my medicine and stuff like that because she was afraid that I had "HIV," quote, unquote, without even looking at the paperwork and stuff like that …. When she [mom] said, "Daughter [participant was male assigned at birth]," the doctor just, basically, had a meltdown and just walked out. [Alice, 22, transwoman]

Similarly, Christine described a negative experience where a provider questioned her gender identity by trying to talk her out of her transition, causing her to question her provider's intentions and discouraging her from wanting to return to that provider to seek care: "The first meeting, she seemed very judgmental. She seemed like she was trying to talk me out of my transition …. it was just like she didn't have my best interest at heart …. Needless to say, I changed doctors" [Christine, 30, transwoman].

These kinds of negative experiences were common among transwomen in the sample, where providers refused or failed to deliver health care services appropriately due to participants' diverse SGM identities, accentuating provider failure, unpreparedness, and discomfort delivering care to SGM individuals. As explained by participants, providers need to "…be aware that there's certain sensitivities to certain people, that not all people are on one spectrum" [Jessica, 27, transwoman] and "feel comfortable with themselves" [Beatriz, 32, transwoman] in order to allow for patients to "feel comfortable, and safe, and in a secure place and environment" [Christine, 30, transwoman] within health care settings.

Correct use of pronouns was challenging for many health care providers and interfered with the development of a trusting patient–provider relationship. For example, Beatriz described an experience where a provider repeatedly used incorrect pronouns to refer to her, causing her to distrust the provider and feel uncomfortable and upset, as calling someone by the incorrect pronoun can be hurtful and discriminatory (Human Rights Campaign, 2018b):

> …the guy [doctor] comes in and my name is Alexander Smith [name on official records], you know, on there … he looks at me and he says Mr. Smith … you look at me, I'm very feminine. So, no. It's Miss Smith … so then he leaves out, comes back into the room and says Mr. Smith again … now this has to stop. He immediately wants to do surgery on my mouth. I'm like you're not getting into my mouth … [Beatriz, 32, transwoman]

Indeed, Marlene, a 32-year-old bisexual transwoman, emphasized the importance of providers to not assume someone's pronouns and say "Sir," 50 million times or "Ma'am" 50 million times" incorrectly. As explained by Jessica, 27, transwoman, one thing providers should always do in order to increase SGM patient comfort during the receipt of health care services is to, "first ask someone their pronouns or what they would like to be referred to." This could prevent misgendering and accidentally upsetting someone.

Similarly, the ways in which providers asked questions often made MSM participants uncomfortable. Participants noted that providers could come off the wrong way, particularly when they asked seemingly unnecessary

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and meddlesome questions. Indeed, Elijah (32-year-old MSM) explained that providers should not ask questions that come off as "judgmental" or "nosy" and "just for the sake of … not actually trying to assign a medical and scientific value to the questions" and should conduct themselves as "professional" and "nonbiased," only asking those questions that are "pertinent to the person and why they're there [at the physician's office]." Nicholas (31-year-old MSM) stated that providers needed to adapt and be sensitive to the needs of SGM persons through more sensitive communication and health care delivery; providers should "put themselves in the place of the person that's their patient," and be "understanding" and "welcoming." Doing this would help the patient "feel comfortable" and encourage them to be "completely honest with you."

MSM PLWH participants cited examples where providers used judgmental and negative communication, but in the context of their HIV status. Steven, a 32-year-old MSM PLWH, described an experience where a provider used negative and judgmental nonverbal communication, demonstrating what a provider's inappropriate reactions could look like, and how an upset patient could either leave or not return for a second visit:

> … it felt like I was going into the GOP [Grand Old Party, i.e., Republican party] camp, and it was like, I'm getting all kinds of crazy faces, and those kind of things, I go for one visit and that's it. And sometimes I've left in the middle of a visit … we're here to be professional … and if you can't get onboard with that, then you're definitely not the practitioner for me at all. [Steven, 29, MSM, PLWH]

Robert (31-year-old, MSM, PLWH) also described an experience where he felt judged negatively by a provider as a result of having HIV, highlighting how a provider could make inappropriate assumptions based on a patient's HIV status:

> I can remember around when I was first diagnosed and going to the doctor and being asked questions about my sexual history and feeling like it was assumed that because I was HIV positive that I was engaging in risky behavior …. [Robert, 31, MSM, PLWH]

Participants discussed the mental health burden that comes with living with HIV and how providers could practice medicine in a way that was insensitive to this burden. For example, Steven discussed the discomfort of feeling judged by providers on top of having to deal with the emotional and mental ramifications of living with HIV:

> … it was uncomfortable for me [getting care], I felt like I was being judged with every answer that I was giving, and that wasn't what I was about. Like, I'm coming in here for medical treatment, I'm coming in here for, sometimes, emotional treatment, you know what I'm saying? To try to figure out. Because being positive or having any kind of disease, you know, it takes an emotional toll as well, as well as mental… [Steven, 29, MSM, PLWH]

Establishing a Personal Bond, Trust, and Familiarity

Transwomen participants, but not MSM participants, particularly emphasized a need for providers to establish a personal bond with them, indicating that it was necessary to build trust and comfort with providers in order for them to return for health care services. Participants wanted providers to be genuinely interested in them, care about them, and be supportive and encouraging. For example, Alice described how this type of relationship could lead to open communication:

> It was just like he got to know me as a person and just not a curable patient. I don't know. I feel like more providers need to do that, sit down, laugh, and try to get to know their patients more, especially the ones that are transgender and stuff because it's the hardest thing in the world …. He just makes me feel that he's just another friend of mine that I can just talk to ….That's what I like about him. [Alice, 22, transwoman]

Indeed, Marlene said that providers could "act like they care more, other than being like a robot" in order to improve conversations and facilitate the health care process between transwomen patients and their providers. Transwomen participants provided examples where a personal bond with providers was lacking. Beatriz expressed the desire for this personal bond and explained that providers sometimes won't discuss topics they are uncomfortable with and will refer patients elsewhere to address these needs:

> … the provider usually doesn't talk about that stuff [trans-identity mental health issues]. They'll usually refer you to someone else that talks about that stuff, you know? She [physician] tried to refer me to someone, but I never went … I would like to talk to her about it. [Beatriz, 32, transwoman]

Establishing a patient–provider bond over time could lead transwomen to feel more comfortable with their providers, leading to a trusting patient–provider relationship. As Alice shared

> Three years ago was when I found out that I was actually transgender because he had asked me why I got institutionalized and stuff like that. I told him why … he just, basically, sat there and talked to me and made me feel comfortable. That's why he knew I was from a different background. He knew I had trust issues. He, basically, sat there and every time I came in, he made me feel comfortable. He made me laugh and talk about stuff that was goofy and stuff. I got to sit there, and I got to know about him, and he got to know about me and then we could be able to talk about stuff. [Alice, 22, transwoman]

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A stark contrast was noted between providers with whom transwomen had developed a bond and those with whom they had not. Participants commonly shared that getting care from a new provider could be acutely uncomfortable, particularly when discussing sensitive health topics. Alice (22, transwoman) explained that "Just to sit there and talk to a complete stranger is not cute at all [i.e, not comfortable]." When transwomen had established trust and a longer-standing relationship with providers, they tended to be more pleased about the patient–provider relationship. For example, Helen (26, transwoman) explained that she's "been seeing this doctor for about … 2 year" and she's "satisfied with what they have done so far." Christine (30, transwoman) had been seeking care from her provider for some time and described her relationship with her provider as "very open" and "really good"; one in which she could be candid, honest, and forthcoming while maintaining the lines of respect and comfort. Jessica (27, transwoman), who has been consistently seeking care from her regular provider, said that the "doctors usually make [her] feel comfortable," and that she thinks that "they've done pretty good for [her]."

Discussion

To our knowledge, this is the first qualitative study to describe and compare the health care experiences of Black MSM and transwomen. It fills knowledge gaps about what it means to be a culturally sensitive provider, allowing for appreciation of the differences between the needs of Black MSM and transwomen. The information and knowledge gained from our participant interviews have important implications for health care providers and organizations that serve Black MSM and transwomen.

Black transwomen indicated the need for establishing a personal bond with providers, which is a novel finding not found in existing literature. Most published qualitative research examining transgender health care experiences have identified themes related to cultural insensitivity, discrimination/prejudice, mistreatment, and lack of skills and knowledge to provide optimal care for transgender patients (Dowshen et al., 2017; Kosenko et al., 2013). We have provided qualitative narratives showing that Black transwomen desire and prioritize a trusting, close, and personal relationship with health care providers. Without this kind of relationship, Black transwomen in our sample suggested that they might not continue care. This need suggests a health care inequity, in which barriers exist that may not allow Black transwomen to receive the optimal health care they require. It is possible that providers would disagree with having this kind of relationship with a patient; becoming too personally involved could be perceived as violating boundaries of professionalism with clients and increase bias in making the most ethically, scientifically, and professionally sound health care decisions. Nevertheless, this is what Black transgender women in our sample said they needed. The findings suggest that sometimes the need for empathy by a patient can override what is considered "standard" in the practice of health care.

Much of the information we gained suggests that many negative health care experiences result from inappropriate verbal and/or nonverbal provider communication. Participants felt that negative experiences with health care providers discouraged them from returning to that provider for health care and from seeking health care services in general, suggesting a need for more SGM cultural sensitivity training and education, particularly as related to communication between Black SGM patients and providers (Garbers, Heck, Gold, Santelli, & Bersamin, 2017; Ruud, 2018). Indeed, several participants cited the need for SGM education for providers to meet the needs of Black SGM populations.

Our findings are aligned with the Minority Stress Theory, which posits that health disparities among SGM can be explained by stressors related to homophobia and transphobia, something not experienced by cisgender heterosexuals. Homophobia and transphobia can lead to harassment, maltreatment, discrimination, and victimization of SGM (Meyer, 2003). SGM may require health care and interactions that are different from those needed by other groups because of exposures to stressful stigma-related experiences and traumas that make it harder to achieve the same level of health as less stigmatized groups (Meyer, 2003).

Differences in stigma-related experiences between groups may explain differences in our findings regarding the health care needs of Black MSM compared with transwomen. Researchers have found that SGM individuals of color may experience minority stress differently in comparison with White SGM individuals, particularly as related to racial stigma (McConnell, Janulis, Phillips, Truong, & Birkett, 2018), which has been supported by studies that have identified racism as a unique and added stressor to the minority stress experiences of racial minority SGM individuals (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Calabrese, Meyer, Overstreet, Haile, & Hansen, 2015; Han et al., 2015; Wong, Schrager, Holloway, Meyer, & Kipke, 2014). Race is clearly a consideration that cannot be ignored in the health care of Black SGM clients. Although we did not ask participants, all of whom were Black, about the specific impact that race had on their

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experiences receiving health care services, it must be acknowledged that Black race, in addition to SGM status, likely contributed significantly to their perspectives about health care (Arnold et al., 2014). Considering that Black SGM experience social and structural health care challenges, minority stress, and an increased risk for HIV, examining the specific perspectives of Black SGM about how race and SGM status impact health care is a gap in the literature that needs to be addressed. Indeed, a systematic review highlighted race as a key construct that influenced Black SGM health care experiences and called for more research on the intersection of sexual/gender and racial minority identities (Peek et al., 2016). Our findings suggest that SGM provider cultural sensitivity training programs need to be tailored for specific races and SGM identities in order to effectively address the needs of SGM subgroups.

Some recommendations from participants were more relevant at the organization and systems levels. Participants discussed issues with health care settings and provider practices that could be addressed through SGM inclusive policies and organization change. For example, policies and procedures are needed to ensure correct pronoun use and accurate collection of sexual orientation and gender identity information. Although providers should have training in SGM cultural sensitivity, systems and organizations should have policies and resources that support and encourage providers to deliver culturally appropriate health care for SGM clients. The Human Rights Campaign Healthcare Equality Index (Human Rights Campaign, 2018a) is an assessment that promotes SGM-supportive policy reform and organization change. The Healthcare Equality Index helps health care organizations assess the quality of their policies and practices in addressing SGM health care needs. The Human Rights Campaign also offers post-assessment training and resources to help organizations address gaps regarding SGM supportive policies, systems, and resources (Human Rights Campaign, 2018a).

A number of participants cited the need for more SGM representation among health care providers and staff to increase patient comfort, because SGM providers and staff would better understand the unique needs of SGM clients. This points to a larger systems-level need in health care. The U.S. population is becoming increasingly diverse, and calls for more diversity among health care providers have been made by the U.S. Department of Health and Human Services (2006; 2015) and affiliated organizations in regard to race, ethnicity, and socioeconomic background (Council on Graduate Medical Education, 2016). However, there have been no calls to increase health professions' diversity in terms of sexual orientation and gender identity, despite increasing numbers of SGM-identifying individuals (Newport, 2018). Increasing diversity among health care professionals may increase access to culturally sensitive health care through an increased number of culturally sensitive providers, who would be more likely to serve underrepresented communities and share their cultural sensitivity skills (Council on Graduate Medical Education, 2016; U.S. Department of Health and Human Services, 2006; 2015). These conclusions have been supported by research that has called for more SGM diversity among health care providers and has shown that lack of SGM diversity impacts health care, particularly for individuals whose identities may be marginalized, such as Black SGM (Dowshen et al., 2017; Martos et al., 2018).

Limitations and Strengths

Our study had several limitations. First, analysis was based on individual interviews with Black MSM and transwomen and thus relied solely on self-report, which carries risks of social desirability and recall bias. Although all participants seemed to be forthcoming, they may have withheld details of their experiences in these face-to-face interviews. Second, constraints related to the funder's research priorities, which focused on MSM and transwomen of color, and study budget affected the study's sample size and eligibility criteria. Ideally, additional participants from each group (Black MSM and Black transwomen) who are with and without HIV infection would have been sampled using grounded theory methods. Our goal was an initial, in-depth thematic analysis of Black MSM and transwomen's experiences of health care, but further exploration is advised regarding how health care experiences differ between SGM groups and among those living with and without HIV. Third, most transwomen participants were recruited from a support group, and all MSM were recruited via geospatial dating apps, potentially limiting transferability of these results to other populations of transwomen and MSM who do not participate in support groups or dating apps. That all transwomen were HIV uninfected and more than half of MSM participants were living with HIV further affects transferability of findings to transwomen living with HIV and HIV-uninfected MSM. Finally, the study could have been enhanced by use of member checking once results were prepared by the research team.

Despite these limitations, our study has several methodological strengths and contributes to existing literature, providing the first known comparison of health care experiences between Black MSM and transwomen. The

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in-depth and personal narratives highlight the voices and perspectives of marginalized, underrepresented, and hard-to-reach individuals who have not been adequately represented in research. Additionally, our findings were consistent with other studies indicating that Black MSM and transwomen face barriers to health care, giving credence to the credibility of our findings (Arnold et al., 2014; Fields et al., 2016; James et al., 2017; Macapagal et al., 2016). Finally, undue bias of any individual researcher was reduced through the use of strategies to enhance study rigor and trustworthiness of findings, including use of a systematic analytic approach, multiple coders, and triangulation of interpretations across multiple researchers throughout data analysis.

Conclusion

Our findings relay important considerations to improve Black SGM health care at the client and organization levels. Black SGM persons felt that providers did not meet their needs in several unique ways based on their specific sexual and gender identities and HIV status. Black SGM articulated forms of provider communication that they found particularly alienating or helpful, and ways in which health care organizations, systems, and policies either alienated or facilitated health care. Findings suggest a need for cultural sensitivity training and education to address provider, systems, and organization-level concerns to fulfill the needs of Black SGM, acknowledging that needs may be specific to Black SGM versus SGM of other races. Additionally, needs articulated by MSM and transwomen varied, which speaks to the importance of tailoring cultural sensitivity training programs based on specific SGM identities. For transwomen, it is essential to consider that they may need empathic care that requires providers to adapt and alter their current ways of providing care. Recommendations and implications from our study should encourage further investigation of the health care needs of Black SGM and inform efforts to improve SGM health care cultural sensitivity.

Disclosures

The authors report no real or perceived vested interests related to this article that could be construed as a conflict of interest.

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Key Considerations

- Negative experiences related to race, sexuality, gender, and HIV still occur in health care, often in ways that are not apparent to the provider.
- The care of SGM may be improved by providing cultural sensitivity education at the health care provider (including higher education institutions) and organization levels.
- Providers should reflect consistent use of encouraging, sensitive, supportive, and inclusive language, practice, and behaviors.
- Organizations and higher education institutions can enforce recruitment efforts to increase sexual and gender minority representation among health care providers.

References

Arnold, E. A., Rebchook, G. M., & Kegeles, S. M. (2014). "Triply cursed": Racism, homophobia and HIV-related stigma are barriers to regular HIV testing, treatment adherence and disclosure among young Black gay men. *Culture, Health & Sexuality*, *16*(6), 710-722. doi:10.1080/13691058.2014.905706

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: The LGBT People of Color Microaggressions Scale. *Cultural Diversity & Ethnic Minority Psychology*, *17*(2), 163-174. doi:10.1037/a0023244

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. doi:10.1191/1478088706qp063oa

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum*, *41*(1), 89-91. doi:10.1188/14.ONF.89-91

Calabrese, S. K., Meyer, I. H., Overstreet, N. M., Haile, R., & Hansen, N. B. (2015). Exploring discrimination and mental health disparities faced by Black sexual minority women using a minority stress

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framework. *Psychology of Women Quarterly*, *39*(3), 287-304. doi:10.1177/0361684314560730

Council on Graduate Medical Education. (2016). *Supporting diversity in the health professions*. Retrieved from https://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Publications/diversityresourcepaper.pdf

Centers for Disease Control and Prevention. (2017). *HIV Surveillance Report, 2016*. Retrieved from: http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html

Clark, H., Babu, A. S., Wiewel, E. W., Opoku, J., & Crepaz, N. (2017). Diagnosed HIV infection in transgender adults and adolescents: Results from the National HIV Surveillance System, 2009-2014. *AIDS and Behavior*, *21*(9), 2774-2783. doi:10.1007/s10461-016-1656-7

Centers for Disease Control and Prevention. (2018). *Estimated HIV incidence and prevalence in the United States, 2010-2015. HIV Surveillance Supplemental Report 2018*. Retrieved from https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-23-1.pdf

Dowshen, N., Lee, S., Franklin, J., Castillo, M., & Barg, F. (2017). Access to medical and mental health services across the HIV care continuum among young transgender women: A qualitative study. *Transgender Health*, *2*(1), 81-90. doi:10.1089/trgh.2016.0046

Fields, E., Morgan, A., & Sanders, R. A. (2016). The intersection of sociocultural factors and health-related behavior in lesbian, gay, bisexual, and transgender youth: Experiences among young Black gay males as an example. *Pediatric Clinics of North America*, *63*(6), 1091-1106. doi:10.1016/j.pcl.2016.07.009

Garbers, S., Heck, C. J., Gold, M. A., Santelli, J. S., & Bersamin, M. (2017). Providing culturally competent care for LGBTQ youth in school-based health centers: A needs assessment to guide quality of care improvements. *The Journal of School Nursing*, *34*(6), 424-429. doi:10.1177/1059840517727335

Han, C., Ayala, G., Paul, J. P., Boylan, R., Gregorich, S. E., & Choi, K.-H. (2015). Stress and coping with racism and their role in sexual risk for HIV among African American, Asian/Pacific Islander, and Latino men who have sex with men. *Archives of Sexual Behavior*, *44*(2), 411-420. doi:10.1007/s10508-014-0331-1

Human Rights Campaign. (2018a). *Healthcare Equality Index 2018*. Retrieved from https://assets2.hrc.org/files/assets/resources/HEI-2018-FinalReport.pdf?_ga=2.264041612.169829263.1532022771-574514029.1504056903

Human Rights Campaign. (2018b). *Talking about pronouns in the workplace*. Retrieved from https://assets2.hrc.org/files/assets/resources/TalkingAboutPronouns_onesheet_FINAL.pdf?_ga=2.205117971.2093556983.1540738758-574514029.1504056903

James, S. E., Brown, C., & Wilson, I. (2017). *2015 U.S. Transgender Survey: Report on the experiences of Black respondents*. Retrieved from http://www.transequality.org/sites/default/files/docs/usts/USTS-Black-Respondents-Report.pdf

Kosenko, K., Rintamaki, L., Raney, S., & Maness, K. (2013). Transgender patient perceptions of stigma in health care contexts. *Medical Care*, *51*(9), 819-822. doi:10.1097/MLR.0b013e31829fa90d

Lykens, J. E., LeBlanc, A. J., & Bockting, W. O. (2018). Healthcare experiences among young adults who identify as genderqueer or nonbinary. *LGBT Health*, *5*(3), 191-196. doi:10.1089/lgbt.2017.0215

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674-697. doi:10.1037/0033-2909.129.5.674

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health*, *3*(6), 434-442. doi:10.1089/lgbt.2015.0124

Martos, A. J., Wilson, P. A., Gordon, A. R., Lightfoot, M., & Meyer, I. H. (2018). "Like finding a unicorn": Healthcare preferences among lesbian, gay, and bisexual people in the United States. *Social Science & Medicine (1982)*, *208*, 126-133. doi:10.1016/j.socscimed.2018.05.020

McConnell, E. A., Janulis, P., Phillips, G., II, Truong, R., & Birkett, M. (2018). Multiple minority stress and LGBT community resilience among sexual minority men. *Psychology of Sexual Orientation and Gender Diversity*, *5*(1), 1-12. doi:10.1037/sgd0000265

Newport, F. (2018). In U.S., estimate of LGBT population rises to 4.5%. Retrieved from https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx

Peek, M. E., Lopez, F. Y., Williams, H. S., Xu, L. J., McNulty, M. C., Acree, M. E., & Schneider, J. A. (2016). Development of a conceptual framework for understanding shared decision making among African-American LGBT patients and their clinicians. *Journal of General Internal Medicine*, *31*(6), 677-687. doi:10.1007/s11606-016-3616-3

Raifman, J., Beyrer, C., & Arrington-Sanders, R. (2018). HIV education and sexual risk behaviors among young men who have sex with men. *LGBT Health*, *5*(2), 131-138. doi:10.1089/lgbt.2017.0076

Ruud, M. (2018). Cultural humility in the care of individuals who are lesbian, gay, bisexual, transgender, or queer. *Nursing for Women's Health*, *22*(3), 255-263. doi:10.1016/j.nwh.2018.03.009

U.S. Department of Health and Human Services. (2006). *The rationale for diversity in the health professions: A review of the evidence*. Retrieved from https://www.pipelineeffect.com/wp-content/uploads/2015/04/diversityreviewevidence.pdf

U.S. Department of Health and Human Services. (2015). *Sex, race, and ethnic diversity of U.S. health occupations (2010-2012)*. Retrieved from https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/diversityushealthoccupations_2012.pdf

U.S. Department of Health and Human Services. (2017). *National HIV/AIDS Strategy for the United States: 2017 Progress Report*. Retrieved from https://files.hiv.gov/s3fs-public/NHAS_Progress_Report_2017.pdf

Wong, C. F., Schrager, S. M., Holloway, I. W., Meyer, I. H., & Kipke, M. D. (2014). Minority stress experiences and psychological well-being: The impact of support from and connection to social networks within the Los Angeles House and Ball communities. *Prevention Science*, *15*(1), 44-55. doi:10.1007/s11121-012-0348-4

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